



## Reciprocity Application

### Idaho Emergency Medical Services Bureau

Send completed form to Idaho EMS Bureau, PO Box 83720, Boise, ID 83720-0036 or  
Fax to 208-334-4015



**Level Applying For:** ☐ Emergency Medical Responder ☐ EMT ☐ Advanced EMT (\$35 fee) ☐ Paramedic (\$35 fee)

**Fee (if required):** ☐ \$35 enclosed (exact cash, check, or money order only) **OR** ☐ Direct Bill - Agency Name \_\_\_\_\_

**Signatures:** ☐ Affiliating Agency Official ☐ Applicant **Required attachment:** ☐ Copy of ID (Drivers License, Idaho Identification card, or Military Identification ID card)

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Drivers License # \_\_\_\_\_ DL State \_\_\_\_\_

Name \_\_\_\_\_ Gender ☐ F ☐ M  
Last Name First Name Middle Name

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Circle the highest level of education: GED / High School Diploma / College: 1 2 3 4 5 6 7 8

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

#### Affiliation:

Qualifying Agency of Affiliation \_\_\_\_\_ Agency License # \_\_\_\_\_

Agency Authorized Signature \_\_\_\_\_  
Signature Printed Name

Career status for qualifying agency: Volunteer ☐ True ☐ Compensated Career ☐ Full Time ☐ Part Time

List all agency or hospital affiliations or associations (Use additional form if necessary.)

Agency/Hospital \_\_\_\_\_ Volunteer ☐ True ☐ Compensated Career ☐ Full Time ☐ Part Time

Agency/Hospital \_\_\_\_\_ Volunteer ☐ True ☐ Compensated Career ☐ Full Time ☐ Part Time

Agency/Hospital \_\_\_\_\_ Volunteer ☐ True ☐ Compensated Career ☐ Full Time ☐ Part Time

*I am also an Idaho licensed/certified health care provider as a(n)* (circle all that apply): MD / DO / PA / RN / RT / other (please specify) \_\_\_\_\_

*Have you ever applied for or held an EMS certificate or license in any other state?* Yes ☐ No ☐

*Have you ever been denied or had revoked an EMS certificate or license in any other state?* Yes ☐ No ☐

If you answered yes to either question, complete an *Idaho EMS License Verification Request* form for each state in which you have ever applied for, been denied, had revoked or held an EMS certificate / license. (This form is available at [www.idahoems.org](http://www.idahoems.org) under Provider Licensure Forms)

I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS licensure as established by the State of Idaho.

Signature of Applicant \_\_\_\_\_

Date signed \_\_\_\_\_

#### For Bureau Use Only

Received by Bureau

Cert. Fee Rcvd Date \_\_\_\_\_

☐ Cash - Receipt # \_\_\_\_\_

☐ Check # \_\_\_\_\_

☐ M.O. # \_\_\_\_\_

☐ DB - Agency \_\_\_\_\_

**Required Criminal History Check**-Accessible on line at [www.chu.dhw.idaho.gov](http://www.chu.dhw.idaho.gov).

Idaho EMS Bureau Employer ID #1350

Create new registration and complete application using Idaho EMS Bureau ID# and schedule fingerprinting appointment. Criminal History check must be cleared before the Idaho EMS Bureau can issue a state license, which must be obtained to practice EMS in the State of Idaho.

# IDAHO EMS LICENSE VERIFICATION REQUEST

Have you ever applied for or held an EMS certificate or license in any other state?

Have you ever been denied or had revoked an EMS certificate or license in any other state?

☐ Yes – complete this form for each state in which you have ever applied for, held or been denied an EMS certificate/license.

☐ No – completion of this form is not required

## Authorization to release information to the IDAHO EMS BUREAU (Please Print)

Name: \_\_\_\_\_ Also Known As: \_\_\_\_\_  
Last First M.I. Alias, Maiden, or Nicknames

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_.

Mailing Address: \_\_\_\_\_ Phone # \_\_\_\_\_  
Street City State Zip

I hereby authorize the state of \_\_\_\_\_ EMS licensing agency to furnish the information requested.

\_\_\_\_\_  
Certificate/License Number

\_\_\_\_\_  
EMS Level

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date signed

## THIS PORTION MUST BE COMPLETED BY THE STATE EMS LICENSING AUTHORITY

### 2. LEVEL

#### 1. STATUS OF CERTIFICATION/LICENSURE

CERTIFICATION / LICENSE #: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_

STATUS: \_\_\_\_\_

#### DOT-NATIONAL STANDARD CURRICULA

☐ FIRST RESPONDER 1994

☐ EMT-BASIC 1995

☐ INTERMEDIATE ☐ I-85 OR ☐ I-99

☐ EMT-PARAMEDIC 1998

#### NATIONAL SOP MODEL

☐ Emergency Medical Responder (EMR)

☐ Emergency Medical Technician (EMT)

☐ Advanced EMT (AEMT)

☐ Paramedic

**3. HAS YOUR STATE TAKEN ANY DISCIPLINARY ACTION AGAINST THIS PERSON RESULTING IN A SUSPENSION, PROBATION, REVOCATION OR DENIAL FOR EMS CERTIFICATION OR LICENSURE?** ☐ YES ☐ NO  
IF YES, PLEASE DESCRIBE (Use Attachment if needed)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. IS THIS INDIVIDUAL CURRENTLY UNDER INVESTIGATION BY YOUR AGENCY?** ☐ YES ☐ NO

IF YES, UPON COMPLETION OF INVESTIGATION, PLEASE NOTIFY THE IDAHO EMS BUREAU OF THE OUTCOME AND ANY DISCIPLINARY ACTION.

I hereby certify that the above information is true and correct recorded by this office.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency Name

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Boise, ID 83720-0036

